



December 26, 2008

Submitted Electronically

Kerry Weems, Acting Administrator
Centers for Medicare and Medicaid Services
US Department of Health and Human Services
Attn: CMS 1403-FC
Mail Stop: C4-26-05
7500 Security Boulevard,
Baltimore, MD 21244-8050

RE: **CMS 1403-FC – Stereotactic Radiosurgery Codes** – Medicare Physician Fee Schedule (MPFS)

Specific Subject: Stereotactic Radiosurgery Coding for Neurosurgeons

Dear Acting Administrator Weems:

On behalf of the International RadioSurgery Association¹ (IRSA), I am writing to you regarding the composition and accuracy of the proposed work RVUs (Relative Value Units) for the new stereotactic radiosurgery professional coding (particle beam, gamma ray or linear accelerator): CPT codes 61796, 61797, 61798, 61799, 61800, 63620 and 63621, which are to replace CPT 61793 on January 1, 2009.

BACKGROUND

IRSA represents only stereotactic radiosurgery (SRS) centers that are hospital based. Our members perform SRS in one-session procedures on cranial or spinal locations. Because of the costs of the equipment and the building (\$4–6 Million) required to establish a center, as well as regulatory constraints, it is impractical as well as nearly impossible for a center to exist outside of a hospital entity. This means that the Medicare recipient is already hampered by the unavailability of SRS on a wide-spread basis.

SRS was first brought to America by a neurosurgeon in 1987 and developed by neurosurgeons. Currently, there are only about 250 units where one-session or up to five-session SRS is performed; yet America has over 5,000 hospitals. Stereotactic radiosurgery is performed in lieu of an open skull procedure. It does not replace the need for radiation therapy. Over 3,000 peer reviewed articles exist attesting to its safety, lack of side effects and lack of long-term health issues which accompany open skull surgery. The use of SRS has saved the health care system and Medicare enormous amounts of precious health care dollars.

Stereotactic radiosurgery is a multi-disciplinary procedure which requires a neurosurgeon and a radiation oncologist. The neurosurgeon normally brings the patient, who may or may not have the option of open skull surgery depending on his condition and disease process. The neurosurgeon decides whether a patient

¹ IRSA is a trade association representing 60 hospital-based radiosurgery centers; more than 90% of all USA centers are our members. The association is dedicated to providing guidance, research and education on radiosurgery to government agencies, insurers, physicians and patients.

should receive SRS. The neurosurgeon also plans the procedure in order to establish safe distances from critical structures in the brain and previous surgeries. Often SRS is performed for functional brain disorders, not tumors. Functional brain disorders include pain, tremors, psycho-neurological issues, and brain cysts. Stereotactic radiosurgery also treats arterio-venous malformations (a tangle of vessels in the brain), and other non-tumor problems. The neurosurgeon brings the skill of identifying the correct nerve or vein to target as well as identifying any critical structures.

The radiation oncologist brings another set of skills and experience to the procedure by providing information on additional radiation and working with the neurosurgeon. Each professional is a vital part of the procedure. Both specialties are required to remain present during the procedure, which lasts from 4–6 hours.

CMS USED FLAWED INFORMATION

Specifically, we are concerned with the new CPT codes 61796, 61798, and 63620 which are designated for neurosurgeon use. CMS, in its November 19, 2008 release, has chosen to ignore the RUC (Relative Value Unit's Updating Committee) recommendations for the Work RVUs for these three codes. Additionally, CMS has chosen to ignore the specialty society recommendations for these codes.

CMS stated in its release:

“Regardless of the clinical background or training received by the clinician, we believe the work involved in providing radiation therapy services or [stereotactic] radiosurgery radiation therapy is similar, and that the work relative values should be similar.”

CMS has based its decision on unreliable input and data, which at best is lacking in accuracy. During radiation therapy services a radiation oncologist uses technicians to administer the therapy and in general sees the patient once each week. Multiple patients may be in therapy at the same time with one radiation oncologist in the suite to oversee the therapist and technicians. Stereotactic radiosurgery is much more intense and unforgiving than radiation therapy; SRS administers the total radiation dose in one session instead of over 4–6 weeks as in radiation therapy. Stereotactic radiosurgery requires both disciplines' expertise and direct supervision (the specialists are bodily present) for the entire procedure.

IRSA SURVEY

After the November 19 release, IRSA conducted a survey of all members to establish which CPT codes the radiation professional bills for SRS. We specifically asked the hospital coders and/or radiation oncologists who performs the radiosurgery procedure with the neurosurgeon, to supply us with the CPT codes they bill when performing the SRS procedure.

Many responding radiation professionals were upset by the comparison that CMS made between SRS and radiation therapy when they came forth to work with IRSA in this matter. We were told many times that the professional work with radiation therapy was not equal to the work required of the radiation professional when conducting a radiosurgery procedure. The survey resulted in a total response rate of 89%. The respondents perform more than 75% of all one-session SRS procedures in the USA using Gamma Knife,[®] CyberKnife,[®] Synergy-S[®] and Novalis[®] technologies among others.

The following table shows that on the day of the SRS procedure, 100% of those responding state the radiation professional bills for multiple CPT codes which include CPT 77432. There were no differences among the respondents in the CPT codes billed the day of the procedure.

**IRSA Survey of Professional Radiation Billing Codes for SRS One-Session Procedures
As of December 2008**

89% of all members responded, representing over 1/2 of all one-session SRS performed in USA

CPT	Description	Units	Work RVU	Extended Total	Percent Rept Usage of Code																
Days Prior to SRS Procedure: Codes in days prior to procedure were used on different days. Respondents reported the use of 2–3 of the codes below before the procedure day.																					
99204-5	New PT		Range	2.30- 3.07	84%																
99242-5	Consult		Range	1.34- 3.77	65%																
99367	Med. Team Conf.		1.10	1.10	31%																
77470	Spec. RT Mgt		2.09	2.09	72%																
Day of SRS Procedure:		Use of the -59 modifier is used with multiple units																			
77295	Set Field Planning		4.56	4.56	100%																
77263	RT Planning		3.14	3.14	100%																
77300	Dose Planning	Average 8	0.21	1.68	100%																
77334	Devices	Average 3	1.24	3.72	100%																
77432	SR Management		7.92	7.92	100%																
Total Work RVUs Day of Procedure				21.02																	
30 to 60 Days Subsequent to SRS Procedure:																					
99213-4	Office Visit	1 month	Range	0.92-1.42	100%																
99213-4	Office Visit	2 months	Range	0.92-1.42	95%																
Some respondents reported 77470 being billed after day of procedure instead of before.																					
<table><tr><td colspan="4">Work RVU Totals</td></tr><tr><td colspan="3">Minimum</td><td>25.30</td></tr><tr><td colspan="3">Maximum</td><td>29.02</td></tr><tr><td colspan="3">Day of Proc.</td><td>21.02</td></tr></table>						Work RVU Totals				Minimum			25.30	Maximum			29.02	Day of Proc.			21.02
Work RVU Totals																					
Minimum			25.30																		
Maximum			29.02																		
Day of Proc.			21.02																		
The reported information is for cranial and spinal one-session SRS procedures. The radiation oncologist and the neurosurgeon are part of an interdisciplinary team and both perform planning, targeting, dosimetry, simulation, treatment delivery and management of the patient.																					

BARRIER TO ENTRY

By using misinformation, CMS is once again creating a barrier to the SRS procedure for patients. As previously stated, most patients are referred to SRS in place of an open skull procedure (craniotomy). This means that a neurosurgeon, neuro-otologist or neurologist has referred the patient for the procedure. By creating inequities in the payment rates for SRS professionals, and ignoring both the RUC's and specialty societies' recommendations, CMS's actions will certainly lower the likelihood that SRS facilities will continue to develop.

By inadequately reimbursing neurosurgical professionals, CMS has created an environment where these professionals will not undergo the extensive training and commitment to learn SRS, and will not ask their hospitals to invest in SRS equipment.

ESTABLISHING APPROPRIATE WORK RVUs

Again, we would like to bring attention to CMS's statement in its November 19, 2008 release:

“Regardless of the clinical background or training received by the clinician, we believe the work involved in providing radiation therapy services or [stereotactic] radiosurgery radiation therapy is similar, and that the work relative values should be similar.”

IRSA also believes that both disciplines should receive similar compensation to keep SRS available to the Medicare recipient. Now that we know CMS can set Work RVUs at will, we respectfully request that CMS use the same rationale as in their MPFS 1403-FC release and establish the Work RVUs for the neuro-professionals at the same level of the Work RVUs for the radiation professionals. The neuro professional is limited to one procedure CPT to bill while conducting the SRS procedure which has a global of 90 days. (61796, 61798 and 63620). The radiation professional can charge a large array of CPT codes with no global limitations. IRSA believes that at a minimum, the following should comprise the Work RVUs for the neuro-professional in performing SRS to bring the Work RVUs for each professional discipline to a similar value as CMS has proposed:

Day of Procedure Radiation Professional Work RVU: 21.02
Half Day Discharge and 2 CPT 99213 Office Visits: 2.87

Total Work RVUs for CPTs 61796, 61798, 63620: 23.89

The resulting Work RVUs of 23.89 still fall far short of the Minimum and Maximum Work RVUs of 25.30 and 29.02 respectively, which were reported by the SRS radiation professionals.

CONCLUSION

IRSA appreciates the opportunity to comment on proposed stereotactic radiosurgery professional coding and the Medicare Physician Fee Schedule final with comment regulation (1403-FC). We are available along with hospital representatives, and professionals who perform SRS to meet with CMS about this issue.

Yours Sincerely,

/Rebecca L. Emerick/elect.sign

Rebecca L. Emerick, MS, MBA, CPA
Executive Director

Cc: Senator Arlen Specter (Appropriations Committee)
Senator Daniel Akaka (Appropriations Committee)

Note: This letter is being copied to every Senator including incoming Health and Human Services Secretary Tom Daschle who is from South Dakota. Both South Dakota and North Dakota do not have the technology to perform one-session SRS and are significantly underserved. Medicare recipients are forced to receive open skull surgery where SRS is not available. This costs CMS a dramatic increase in healthcare dollars and results in further medical issues (infection, anesthesia problems, bleeding, rehabilitation and possible further surgeries) and economic work loss for the patient where SRS is not available. IRSA believes the lack of SRS in these areas often occurs due to regulatory constraints which restrict professionals and hospitals from working together to bring SRS to the Medicare recipient. Inequities in professional reimbursement are now another issue which will affect the future availability of SRS.